BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

DONALD F. STAIR	)	
Claimant	)	
VS.	)	
	)	
PEOPLEASE	)	
Respondent	)	Docket No. 1,046,724
AND	)	
	)	
ARCH INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

Claimant appealed the June 26, 2013, Award entered by Administrative Law Judge (ALJ) Brad E. Avery. The Board heard oral argument on October 15, 2013.

APPEARANCES

Michael G. Patton of Emporia, Kansas, appeared for claimant. Abagail L. Pierpoint of Kansas City, Missouri, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The record considered by the Board and the parties' stipulations are listed in the Award. At oral argument before the Board, respondent agreed that Exhibit 1 to Dr. Yost's deposition transcript and Exhibit 4 to claimant's September 11, 2012, deposition transcript were not offered into evidence and are not part of the record. The parties also stipulated that correspondence in the Division of Workers Compensation (Division) administrative file in this claim is not part of the record.

ISSUES

ALJ Avery denied compensation in this claim. The ALJ concluded claimant failed to prove a personal injury by accident arising out of and in the course of his employment with respondent. ALJ Avery determined the medical evidence indicated it was more likely claimant's toe amputation resulted from his diabetic condition and previous infection of his toe.

Claimant requests the Board reverse ALJ Avery's Award and either remand the matter to the ALJ for a determination of nature and extent of disability or find claimant is permanently and totally disabled.

Respondent contends ALJ Avery's finding that claimant did not sustain an accidental injury arising out of and in the course of his employment is supported by the evidence and should be affirmed. Respondent asserts claimant's testimony cannot be relied upon as it has been contradicted many times. Respondent also asserts claimant: (1) did not provide timely notice of the injury, (2) is not entitled to temporary total disability or work disability benefits, and (3) is not permanently and totally disabled as a result of his alleged injury. Respondent requests the Board affirm the Award and find respondent is entitled to reimbursement from the Workers Compensation Fund for amounts already paid for medical expenses and temporary total disability.

There is a dispute over the exhibits to the deposition transcript of Dr. Peter V. Bieri. Claimant deposed Dr. Bieri on August 28, 2012. The parties introduced 10 exhibits, but only Exhibit 3 was offered into evidence. When the Board received the deposition transcript, only Exhibits 1, 2, 3 and 10 were attached. Exhibits 4-9 introduced at Dr. Bieri's deposition were not attached to the transcript. The Award does not address this issue. That is because neither party raised the evidentiary issues in their submission letters to the ALJ. Nor did either party address this issue in their briefs to the Board. The issue was first raised by respondent, when the Board contacted the parties about Exhibits 4-9, the exhibits missing from Dr. Bieri's deposition transcript.

Respondent asserted in an email to the Board and at oral argument that only Exhibit 3 was offered into evidence and, therefore, only Exhibit 3 is part of the record. At oral argument, claimant asserted all exhibits to Dr. Bieri's transcript are part of the record. Before and after oral argument, the Board contacted the parties, requesting claimant's attorney to provide the missing exhibits. Claimant's attorney indicated that he had none of the Bieri deposition exhibits, so the Board sent the parties Exhibit 10. The Board repeatedly asked claimant's attorney to specify which of the exhibits to Dr. Bieri's deposition claimant asserts are in the record. Claimant's attorney indicated that in addition to Exhibit 3, he wanted Exhibit 2 to be included in the record and was fine with moving forward without Exhibits 4-9. Claimant's attorney has never specified if he asserts Exhibits 1 and 10 should be in the record. Therefore, for purposes of this appeal, the Board can only assume claimant contends Bieri Exhibits 1, 2, 3 and 10 are part of the record.

The parties also disagree over whether Exhibits 4 and 6 to Dr. Andrew J. Green's deposition are part of the record. Exhibit 4 was introduced by respondent at the deposition, but never offered into evidence. Claimant introduced Exhibit 6, but respondent objected that it was hearsay and lacked foundation. The ALJ did not address whether Exhibit 4 is part of the record. That is because the Board, on appeal, discovered Exhibit 4 was introduced, but not offered into evidence. The ALJ did not rule on respondent's

objection to Exhibit 6, as neither party addressed Exhibit 6 in their submission letters to the ALJ. The parties did not address Exhibit 6 in their briefs to the Board.

The issues before the Board on this appeal are:

1. What exhibits introduced at Dr. Bieri's deposition are part of the record? Are Exhibits 4 and 6 to Dr. Green's deposition transcript part of the record?

2. Did claimant prove he sustained a personal injury by accident arising out of and in the course of his employment with respondent? If so,

A. Did claimant provide timely notice of the accident?

B. What is claimant's average weekly wage?

C. Is claimant entitled to additional dates of temporary total disability benefits?

D. What is the nature and extent of claimant's disability?

E. Is claimant entitled to future and unauthorized medical treatment?

FINDINGS OF FACT

After reviewing the entire record and considering the parties' arguments, the Board finds:

Claimant was a truck driver for about 41 years. On May 17, 2009, he obtained employment with respondent as an over-the-road trucker. The tractor which claimant was provided had not been used for a couple of months and had to be jump-started when claimant was first provided the truck. Claimant also noted there were several spiders in the truck. Claimant was able to positively identify a spider he saw in the truck cab as a brown recluse spider. He advised the lead driver, Bill Marsh, of seeing spiders in the truck and was told to get some spray for the cab. Claimant bought the spray and sprayed inside the truck cab. Sometime after June 14, 2009, claimant killed a surviving spider in the cab that crawled on his face.

On Wednesday, June 24, 2009, claimant was traveling from Nashville to Philadelphia in respondent's truck. He slept in the truck cab that night at Carlisle, Pennsylvania. The next morning, he awoke and his right foot was sore. He described his right second toe as having a red spot and a little black dot on the end of the toe. He thought it might be a mosquito bite or bee sting and he put some ointment and an adhesive bandage on it. Claimant indicated he did not see a spider on or near him as he was asleep.

Claimant continued to travel for respondent, and the toe progressively worsened. Within two days, claimant was driving with a house slipper on his right foot. By the Sunday after the accident, claimant's right second toe was painful, black, beginning to smell and was draining. Claimant advised respondent of the worsening condition and was asked to drive to Nashville, Tennessee. In Nashville, claimant was met by his two brothers, one of whom is a licensed EMT. That brother advised claimant he had been bitten by something. Claimant asked that they drive him back to Kansas, which they did.

Claimant was taken to Newman Regional Health (Newman) in Emporia, Kansas, and was attended in the emergency room by Dr. Robert F. Dorsey. Claimant was immediately admitted to the emergency room and into the hospital on June 30, 2009. Claimant's leg had swollen to the point they almost could not remove his pants in the emergency room. Claimant's toe was then amputated by Dr. Michael D. Yost. Claimant remained in the hospital for several days.

The admission records at Newman did not mention a spider bite. Claimant testified he mentioned the bite to Dr. Dorsey. Newman's admission records indicated claimant gave a history of having erythema, or redness, for about a month and noticed his toe turning black over the past several days. Claimant attributed swelling to a blister he had on his right second toe in February or March 2009 from a new pair of cowboy boots. According to claimant, the blister resolved. The discharge summary from Newman listed 13 discharge diagnoses, including controlled non insulin dependent diabetes with peripheral circulatory and neurological manifestations, atherosclerosis of arteries with ulceration and gangrene, peripheral edema, venous insufficiency, toe osteomyelitis and malnutrition, but no insect or spider bite.

Dr. Yost testified he amputated claimant's right second toe because claimant had peripheral vascular disease and a wound that would not heal. Dr. Yost did not ask claimant how he got the wound. The doctor indicated claimant has peripheral circulatory disorder, which is when the arteries are not working as well as they should be and claimant has an increased risk of infections because of diminished blood flow in the area of the amputation. Dr. Yost indicated that persons with diabetes often have peripheral circulatory disorder.

Dr. Yost testified claimant never mentioned having a spider bite. The doctor indicated claimant could have had a spider bite, and due to poor blood flow, the wound from the spider bite might not have healed. Dr. Yost could not state with certainty if claimant's peripheral circulatory problems were caused by claimant's diabetes or the alleged spider bite.

Because he suspected claimant may have Charcot disease in the right ankle, Dr. Yost referred claimant to Dr. Susan K. Bonar, an orthopedic physician specializing in feet and ankles. Charcot disease occurs when the bone begins wasting away. Dr. Yost could not say if a spider bite had triggered claimant's suspected Charcot disease.

Dr. Bonar prescribed claimant a brace for his right foot and determined claimant did not have Charcot disease.

On February 14, 2001, April 26, 2002, and July 2, 2003, claimant saw Dr. Kendall M. Wright with Emporia Family Medicine and requested a refill of glyburide for diabetes. On each of those occasions, Dr. Wright diagnosed claimant with diabetes mellitus. Dr. Wright's July 2, 2003, notes indicated claimant's blood sugar levels were not under good control. Claimant called Emporia Family Medicine for a refill of glyburide on August 9 and October 1, 2004.

On July 22, 2009, Dr. Wright saw claimant and indicated his blood sugars were elevated. The doctor noted claimant was being treated by Dr. Dorsey for an ulcer on the right second toe. Dr. Wright's assessment was that claimant's diabetes was not in good control. Dr. Wright's records do not reflect that claimant ever complained about a spider bite.

At the first preliminary hearing, which was held on September 4, 2009, claimant testified he was diagnosed with diabetes when he had a physical in the spring of 2008. He denied having any problems with his extremities from diabetes. Claimant testified he was given a pill for diabetes, but during a follow-up visit four or five months later he was told his condition was dietary and was taken off the pill. At the September 2009 preliminary hearing, claimant testified that after he sprayed for spiders, he saw one spider sometime after June 14, 2009.

Dr. Amar Patel with Rockhill Orthopaedics saw claimant in December 2009 and January 2010. Dr. Patel indicated claimant had persistent metatarsalgia and diabetic neuropathy, with the neuropathy severe in both feet. An EMG showed severe peripheral neuropathy of the lower extremities.

At the February 5, 2010, preliminary hearing, claimant agreed with his September 4, 2009, testimony that he was diagnosed with diabetes when he had a physical in 2008. Claimant testified he could not remember being diagnosed with diabetes in 1999 and denied taking medication regularly for diabetes since 1999. Claimant's medical records indicated that on February 25, 1999, claimant was diagnosed by Dr. H. Russel Bradley with type II diabetes. Claimant was prescribed DiaBeta, 5 mg daily. Progress notes for three subsequent visits in 1999 mention claimant's diabetes. On February 10, 2000, claimant again saw Dr. Bradley, who indicated claimant was not following his diet well.

Medical records introduced at the February 5, 2010, preliminary hearing disclosed Dr. Dorsey treated claimant at Newman on March 10, 2009, for a blister on the right second toe. A nursing history and physical health review form indicated claimant had the wound two days and it had never completely healed. The cause of the wound was listed as unknown. The nurse who completed the form noted claimant was recently diagnosed with diabetes and was taking a pill once a day for the diabetes, but claimant did not know

the name. The form also indicated claimant checked his blood sugar levels several times a day. An x-ray of the right second toe revealed a considerable amount of soft tissue swelling overlying the tuft of the distal phalanx. Records from Newman indicated claimant had toe cellulitis and a bacterial infection due to streptococcus, Group B. Claimant underwent excisional debridement and was given IV antibiotic therapy. He underwent several days of wound treatment at Newman.

Claimant was deposed on January 19, 2011. He indicated that prior to his toe being amputated, he had no chronic conditions and had taken no medications. Claimant did not remember getting treatment for diabetes. According to claimant, he was told by Dr. Yost laboratory results revealed the toe was injected with spider venom.

At a December 17, 2010, preliminary hearing, claimant requested medical treatment for his back from Dr. Glenn M. Amundson. Claimant asserted he developed back pain from an altered gait caused by the amputated toe. The ALJ granted claimant's request for medical treatment with Dr. Amundson. When Dr. Amundson saw claimant the first time on January 26, 2011, claimant indicated his right second toe was amputated after the toe became septic from a spider bite.

According to Dr. Amundson, claimant indicated he had not been diagnosed with diabetes until after the amputation. Dr. Amundson, after reviewing claimant's medical records, discovered claimant had indeed been diagnosed with diabetes in 1999 and had been treated for diabetes, on and off, since then. Dr. Amundson opined claimant's prior medical records indicated his diabetes was poorly controlled. Claimant did not tell Dr. Amundson that the amputated toe was previously infected in March 2009.

On February 13, 2011, Dr. Amundson sent a report to claimant's and respondent's attorneys. The report indicated Dr. Amundson was concerned that claimant omitted the history of his diabetes. In April 2011, claimant and Dr. Amundson had a discussion about Dr. Amundson's report. During the discussion, claimant felt as though prior to the amputation, he had never been diagnosed as having full-blown diabetes and only was a borderline diabetic.

At the request of respondent, on February 10, 2011, claimant was evaluated by Dr. Andrew J. Green, an endocrinologist. He has practiced medicine for 20 years and 60% of his patients have diabetes. Dr. Green was told by claimant that he was diagnosed with diabetes at the time he was hospitalized for the amputation of his right second toe and that prior to then he had never been told he had diabetes. After reviewing claimant's medical records, Dr. Green determined claimant had a history of diabetes for more than a decade. According to Dr. Green, "borderline diabetes" is not a medically accepted term. Either a person has diabetes or they do not.

At the time of his evaluation, claimant had a blood glucose level of 335 mg/dL and a hemoglobin A1c of 8.3%, which according to Dr. Green showed poor metabolic control

of diabetes. He explained that hemoglobin A1c measures the average blood glucose level of a person over the previous two or three months. Dr. Green noted that claimant's hemoglobin A1c in April 2002 was 9.7%, which is elevated. Claimant also had hemoglobin A1c of 9.6% in July 2003, and 12.5% when he was hospitalized in July 2009, which Dr. Green described as horrible. Dr. Green testified the diagnostic criterion for diabetes is a hemoglobin A1c of 6.5% or greater. From Dr. Green's review of claimant's medical records, the only time claimant's blood glucose was under good control was when he was in the hospital immediately after his toe amputation. When Dr. Green examined claimant, he was 5' 8.5" tall and weighed 233.4 pounds, which qualified claimant as obese. Dr. Green stated, "I would consider Mr. Stair kind of a case study in what happens when people's diabetes is poorly controlled over an extensive period of time."[1]

With respect to causation, Dr. Green opined in his report:

> One of the most common consequences of a decade of hyperglycemia is the development of diabetic peripheral neuropathy. Mr. Stair has classic manifestations of severe bilateral symmetrical diabetic peripheral neuropathy. Mr. Stair states that the injury to the toe was caused by a spider bite, although it appears this diagnosis was never confirmed by a medical professional. Given the clinical context of severe peripheral neuropathy with insensate toes, it is more likely that he developed a typical diabetic pressure ulcer of the toe, which subsequently became infected. When he noticed the lesion, my guess is that his diagnosis simply reflected his experience with similar lesions, which to his eye resembled a spider bite.[2]

Dr. Green explained that when a person develops diabetic neuropathy, he or she loses sensation. Next, a type of muscle imbalance happens that affects the architecture of the foot causing the foot to bear weight in an abnormal way, putting increased pressure on small points of the skin. The skin at the point of pressure breaks down and wears through. Because of the loss of sensation, the diabetic does not appreciate what is happening and a diabetic pressure ulcer results. A diabetic pressure ulcer infection can be to the superficial skin or to the deep structure within the foot. On cross-examination, Dr. Green acknowledged that with claimant's high blood sugars a spider bite would cause claimant to have increased susceptibility to infection and poor wound healing than someone without diabetes or someone with diabetes and good blood sugar control.

At Dr. Green's deposition, respondent introduced Exhibit 4, a task list, but did not offer it into evidence. Claimant introduced Exhibit 6, a document from Wal-Mart Pharmacy concerning the drug, Gabapentin. Respondent objected that the document was hearsay and lacked foundation.

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[1] Green Depo. at 22.

[2] *Id.*, Ex. 2 at 2-3.

By order of the ALJ, claimant was evaluated by Dr. Donald T. Mead on July 21, 2011. Claimant gave a history of being bitten on the second toe of his right foot by a spider. Dr. Mead reviewed claimant's medical records and physically examined claimant. Claimant told Dr. Mead of having a history of diabetes and being sat down by his doctor some years earlier and told the consequences of diabetes. At the time, claimant became scared, quit smoking and drinking alcohol, improved his diet, started exercising and cured his diabetes with a lifestyle change. Claimant reported that his current diabetes was caused by impurities in the generic Neurontin he was taking. Dr. Mead gave the following causation opinion:

> The medical records indicate that in the months prior to the alleged spider bite he had been diagnosed with right second toe cellulitis and ulceration, not a blister[.] The records also document that he had received treatment more involved that *[sic]* just taking some antibiotics as he described, there is documentation of debridement of the ulcer. The description in his records of the toe ulcer and lack of pain with debridement combined with his medical history make it very likely that the wound was a diabetic ulcer. There is no medical documentation that the ulcer healed. Hemoglobin A1C testing upon admission for toe amputation indicates that he was also a poorly controlled diabetic for the three months prior to admission. At this late date, I cannot medically determine if the wound that proceeded *[sic]* the toe amputation was related to a spider bite or from a diabetic ulcer but based on the documents provided, it is more likely to have been a diabetic ulcer.[3]

Claimant was evaluated at the request of his attorney by Dr. Peter V. Bieri, a fellow of the American Academy of Disability Evaluating Physicians, on May 7, 2012. Dr. Bieri testified claimant gave a history of sustaining a spider bite on his right second toe. It was Dr. Bieri's opinion that claimant's toe injury, subsequent amputation and impairment were related to the spider bite. He agreed that in rendering such an opinion, he was relying on the history given by claimant. Dr. Bieri acknowledged he was not an expert on spiders and may have seen one brown recluse spider bite in his clinical career. He did not see anything in Dr. Dorsey's records that claimant had been bitten by a spider.

Dr. Bieri testified claimant admitted having a history of diabetes mellitus. Dr. Bieri acknowledged claimant's diabetes has been mostly under poor control for the past 10 to 12 years. The doctor also confirmed that when claimant was admitted at Newman in June 2009, his blood sugar level was 280, which is quite high, as 120 is considered normal. Dr. Bieri indicated he was aware of claimant's March 2009 "blister," but that claimant gave a history that the blister had healed or was nonexistent at the time claimant was allegedly bitten by the spider.

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[3] Mead Report at 11.

Dr. Bieri acknowledged he was not an endocrinologist and would defer to an endocrinologist on the diagnosis, treatment and management of diabetes. He agreed that one of the common complications of long-term uncontrolled diabetes is neuropathy.

At Dr. Bieri's deposition, claimant introduced Exhibits 1 through 3 and respondent introduced Exhibits 4-10. Only Exhibit 3 was offered into evidence. When the Board received Dr. Bieri's deposition transcript, only Exhibits 1, 2, 3 and 10 were attached.

Claimant was again deposed on September 11, 2012, and testified he woke up in the sleeper cab on June 25, 2009, and noticed a red mark on his right second toe. Claimant testified he was bitten by a spider, but did not see the spider. Claimant testified he saw spiders the night he went to sleep, June 24, 2009, and killed them. He again insisted that before the toe amputation he had never been diagnosed as having diabetes:

> Q. (Ms. Pierpoint) I want to be sure I'm clear on your testimony about your pre-existing diabetes. Are you testifying before this alleged spider bite you were borderline diabetic?
>
> A. (Claimant) That's what I had been told by numerous doctors.
>
> Q. Never been diagnosed as diabetic?
>
> A. Right. Never been diagnosed.[4]

Claimant testified that in 2004, he had an active job, quit smoking and drinking alcohol and lost almost 100 pounds. He checked his blood sugar levels and noticed they were dropping and he thought his borderline diabetes was over. Claimant indicated he took medications for diabetes in the past, but not on a regular basis.

According to claimant, in March 2009, he had three blisters from new cowboy boots, one on the amputated toe and two on his calves. He acknowledged not telling Dr. Bieri about having a previous medical issue with the amputated toe, because the blisters were not work related, the blisters healed and he did not think it was important.

PRINCIPLES OF LAW AND ANALYSIS

Both parties assert that certain exhibits to the depositions of Drs. Bieri and Green should be excluded. The ALJ set forth the record on page one of the Award. The Board will consider the same record the ALJ considered, except for correspondence contained in the Division's administrative file, Exhibit 1 to Dr. Yost's deposition and Exhibit 4 to claimant's September 11, 2012, deposition. The ALJ and Board are not bound by

[4] Stair Depo. (Sept. 11, 2012) at 61.

technical rules of procedure and are to give the parties a reasonable opportunity to present evidence. K.S.A. 2008 Supp. 44-523(a) states:

> The director, administrative law judge or board shall not be bound by technical rules of procedure, but **shall** give the parties reasonable opportunity to be heard and to present evidence, insure the employee and the employer an expeditious hearing and act reasonably without partiality. (Emphasis added.)

The next issue for the Board is whether claimant proved he sustained a personal injury by accident arising out of and in the course of his employment with respondent. A claimant in a workers compensation proceeding has the burden of proof to establish by a preponderance of the credible evidence the right to an award of compensation and to prove the various conditions on which his or her right depends.[5] A claimant must establish that his personal injury was caused by an "accident arising out of and in the course of employment."[6] The phrase "arising out of" employment requires some causal connection between the injury and the employment.[7]

Claimant asserts he was bitten by a spider in respondent's truck cab on June 24 or 25, 2009. Claimant bases this assertion upon the following: (1) he sprayed the truck cab to get rid of an infestation of spiders; (2) sometime before June 24, 2009, while in the truck cab, he killed a spider that crawled on his face; and (3) on June 25, 2009, claimant awoke to find a red spot on the tip of his right second toe. At the September 2009 preliminary hearing, claimant said he only saw one spider after June 14, 2009. However, claimant testified at his September 11, 2012, deposition he saw several spiders the night of June 24, 2009, and killed them. Claimant's testimony lacks consistency.

Claimant's reasoning is nothing more than an application of the *post hoc, ergo propter hoc*[8] fallacy; that because on earlier occasions he saw spiders in the truck cab, the red spot on his right second toe must have been caused by a spider bite. Kansas appellate courts have routinely rejected *post hoc, ergo propter hoc* as a sufficient basis to infer a causal link satisfying even minimal legal standards of review.[9]

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[5] K.S.A. 2008 Supp. 44-501(a); *Perez v. IBP, Inc.*, 16 Kan. App. 2d 277, 826 P.2d 520 (1991).

[6] K.S.A. 2008 Supp. 44-501(a).

[7] *Pinkston v. Rice Motor Co.*, 180 Kan. 295, 303 P.2d 197 (1956).

[8] *Post hoc, ergo propter hoc* is Latin for "after this, therefore because of this."

[9] *Chriestenson v. Russell Stover Candies*, 46 Kan. App. 2d 453, 263 P.3d 821 (2011), *rev. denied* 294 Kan. ___ (2012); *Kuxhausen v. Tillman Partners*, 291 Kan. 314, 241 P.3d 75 (2010) and *Gann v. Driver Management, Inc.*, No. 95,368, 2006 WL 3589971 (Kansas Court of Appeals unpublished opinion filed Dec. 8, 2006).

Claimant was diagnosed with diabetes in 1999. Despite the fact that claimant was prescribed and took medications to control his diabetes from 1999 through at least October 2004, claimant insisted he first learned he had diabetes much later. At the September 2009 preliminary hearing, claimant testified he learned of having diabetes when he underwent a physical in 2008. At his September 2012 deposition, claimant testified that prior to his right second toe amputation, he had never been diagnosed with diabetes. Nor did he remember taking medications for diabetes. Claimant told Dr. Mead of having a history of diabetes, but cured it through a lifestyle change.

Claimant attempted to bolster his assertion that a spider bite caused the wound on his right second toe with medical expert Dr. Bieri. The doctor opined claimant's right second toe was bitten by a spider. Dr. Bieri then concluded claimant's right second toe injury, subsequent amputation and impairment were causally related to the spider bite. In arriving at his causation opinion, Dr. Bieri relied on the history given by claimant and ignored or disregarded significant facts and medical evidence that contradict claimant's assertion of a spider bite. The doctor also conceded he had no expertise in spider bites.

Drs. Green, Yost, Mead and Bieri agreed claimant had a history of diabetes. Drs. Bieri and Green indicated claimant's diabetes was under poor control. Dr. Amundson was concerned because claimant omitted the history of his diabetes. Drs. Green and Patel diagnosed claimant with bilateral diabetic neuropathy. Dr. Yost testified he amputated claimant's right second toe because of peripheral vascular disease and a wound that had not healed. Dr. Yost could not state with certainty if claimant's peripheral circulatory problems were caused by claimant's diabetes or the alleged spider bite. Drs. Mead and Green opined the wound on claimant's toe was likely caused by a diabetic ulcer. The Board notes Dr. Green is an endocrinologist and 60% of his patients have diabetes.

The Board finds it significant that a mere three months prior to claimant's alleged spider bite, claimant had sought medical treatment for a wound on the same right second toe. At claimant's September 11, 2012, deposition, claimant indicates the March 2009 right second toe wound was caused by new cowboy boots, despite the fact that records from Newman indicated claimant did not know the cause of the wound. Moreover, claimant disclosed he was diabetic, for which he was taking a daily pill. Claimant asserts his wound from the March 2009 incident was completely healed prior to his alleged spider bite. The Board is hard-pressed to find that the March 2009 wound was mere circumstance, particularly in light of the fact that claimant told the nurse on duty at Newman of being diagnosed with diabetes.

Newman's records from June 2009 do not mention claimant's right second toe wound was caused by a spider bite. The Board finds this a notable omission. Dr. Yost testified claimant did not mention sustaining a spider bite. Claimant counters by arguing in his brief that during the litigation of this claim the ALJ awarded claimant medical treatment and temporary total disability benefits and twice preliminary orders were appealed to the Board and affirmed. However, when those preliminary orders were issued

by the ALJ and affirmed by the Board, neither Dr. Mead nor Dr. Green had examined claimant and rendered their causation opinions.

The Board also observes that claimant's testimony was inconsistent and not credible. Twice he testified that he was diagnosed with diabetes during a 2008 physical. He also testified that prior to his toe amputation, he was only borderline diabetic. Claimant indicated he cured his diabetes with a lifestyle change. He testified he did not remember taking medications for his diabetes; he took a diabetic pill for four or five months, after which his doctor advised it was no longer necessary; and he took medications in the past, but not on a regular basis. Medical records indicated claimant developed an ulcer on his right second toe in March 2009 that was infected and needed debridement, yet claimant described it as a blister that completely healed.

The Board finds claimant failed to prove he sustained a personal injury by accident arising out of and in the course of his employment with respondent. As succinctly stated by ALJ Avery, "The claimant did not see his toe bitten by a spider, nor did he see a spider on June 24 or June 25, 2009 when he was allegedly bitten. There is no medical evidence to support the conclusion the gangrene that ate Mr. Stair's toe away was caused by spider venom or bacteria that resulted from the alleged bite."[10] The evidence strongly supports Dr. Green's opinion that claimant developed a diabetic pressure ulcer on his right second toe, which became infected.

CONCLUSION

1. The Board considers the record as that set forth on page one of the Award, except the Board does not consider as part of the record the correspondence contained in the Division's administrative file, Exhibit 1 to Dr. Yost's deposition and Exhibit 4 to claimant's September 11, 2012, deposition.

2. Claimant failed to prove he sustained a personal injury by accident arising out of and in the course of his employment with respondent.

3. Respondent and its insurance carrier may seek authority from the Director to obtain reimbursement from the Workers Compensation Fund for medical expenses and temporary total disability benefits paid to claimant.

4. It is unnecessary to address the other issues raised on appeal.

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.[11] Accordingly, the findings

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[10] ALJ Award at 4.

[11] K.S.A. 2012 Supp. 44-555c(k).

and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

AWARD

WHEREFORE, the Board modifies the June 26, 2013, Award entered by ALJ Avery to allow respondent and its insurance carrier to seek authority from the Director to obtain reimbursement from the Workers Compensation Fund for medical expenses and temporary total disability benefits paid to claimant. In all other regards, the Award of the ALJ is affirmed insofar as it does not contradict the findings and conclusions contained herein.

IT IS SO ORDERED.

Dated this ____ day of January, 2014.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

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Honorable Brad E. Avery, Administrative Law Judge